



WILLIAMSON COUNTY EARLY CHILDHOOD COOPERATIVE
SIHWIT GROUP ENROLLMENT FORM / CHANGE FORM

NEW ENROLLEE CHANGE IN CURRENT STATUS ANNUAL ENROLLMENT SPECIAL ENROLLMENT: SPECIAL EVENT DATE OF SPECIAL EVENT

THIS AREA TO BE COMPLETED BY EMPLOYER

YOUR NAME (Please Print) Last First Middle Initial

Table with 2 columns: GROUP #, LOCATION #, DATE OF EMP, COV EFF. DATE

ADDRESS Street / Apt #

ADDRESS City State Zip Code

Phone- Home Work e-mail

MALE FEMALE GENDER

Mo. Day Year DATE OF BIRTH

SOCIAL SECURITY NUMBER

SINGLE WIDOWED MARRIED DIVORCED

COVERAGE (Check only those that apply)

MEDICAL SINGLE EMP+ SPOUSE EMP+ CHILD(REN) FAMILY

DEPENDENT INFORMATION (Complete if you elected family Coverage)

Table with columns: DEPENDENT, M, F, FIRST, MIDDLE INT., LAST, SSN#, DATE OF BIRTH (MONTH DAY YEAR)

IF YOUR SPOUSE OR CHILDREN HAVE A LAST NAME DIFFERENT FROM YOURS, PLEASE PROVIDE A MARRIAGE LICENSE AND/OR BIRTH CERTIFICATE. DATE OF MARRIAGE: / /

OTHER INSURANCE

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER GROUP MEDICAL PLAN? YES NO
IF YES, EFFECTIVE DATE OF COVERAGE / /
NAME OF PRIMARY INSURED / POLICY HOLDER DATE OF BIRTH OF POLICY HOLDER / /
NAME OF COVERED DEPENDENT(S)
ID NUMBER NAME OF INSURANCE CARRIER OR TPA
ADDRESS PHONE
NAME OF OTHER EMPLOYER PROVIDING COVERAGE IS MEDICARE/MEDICAID APPLICABLE? YES NO
IS YOUR SPOUSE EMPLOYED? YES NO IF YES, IS SPOUSE ELIGIBLE FOR INSURANCE THROUGH EMPLOYER NOW OR IN THE FUTURE? YES NO
PROVIDE DETAILS
IS THERE A DIVORCE DECREE OR COURT ORDER REQUIRING YOU TO BE FINANCIALLY RESPONSIBLE FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN? YES NO IF YES, PROVIDE COPY
WHO HAS PRIMARY CUSTODY OF COVERED CHILDREN? MOTHER FATHER

BENEFIT WAIVER STATEMENT

I THE UNDERSIGNED CERTIFY THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO APPLY FOR THE GROUP BENEFIT PLAN OFFERED BY THE COMPANY AND AFTER CAREFUL CONSIDERATION HAVE DECIDED TO DECLINE TO ENROLL IN THE COVERAGE HEREAFTER INDICATED.

DECLINE MEDICAL

ARE YOU DECLINING DUE TO COVERAGE IN ANOTHER PLAN? YES NO (IF BLANK, THE PLAN WILL ASSUME "NO")
IF YES, IS THIS OTHER COVERAGE COBRA? YES NO

OTHER (PLEASE EXPLAIN)

IMPORTANT NOTICE: If you refuse coverage for yourself, you automatically refuse coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provide that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I have received and read a summary of the plan description, and any amendments regarding the impact of HIPAA. I certify that the above information is true and accurate.

SIGNATURE OF EMPLOYEE to DECLINE DATE SIGNED

DATE AND SIGN ENROLLMENT FORM ELECTIONS

SIGNATURE OF EMPLOYEE to ENROLL DATE SIGNED

If contributions are required for any of the above coverage, I authorize the Company to deduct from my earnings the applicable contribution(s) for the coverage hereafter listed (if none, please indicate.)